(B) MEDICAL PROGRAMS

- Employees in the IBEW Union (hired prior to 8/1/06)
- Non-Medicare-Eligible IBEW Employees (retired between 8/1/00 and 7/31/06)
- IBEW Non-Medicare-Eligible Participants on LTD (terminated between 8/1/00 and 7/31/06)

	CIGNA OAP (PPO)			Vytra PPO		
	In-Network	**Out-of-Network**	**Aetna (HMO)**	**In–Network**	**Out-of-Network**	**HIP (HMO)**
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Any physician/ facility	Participating physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	No claim forms	Submit claim forms	No claim forms
Age Limit for Dependent Children/Full-Time Student	To age 19/End of the year age 23	To age 19/End of the year age 23	End of the month age 19/End of the year age 23	To age 19/End of the year age 23	To age 19/End of the year age 23	End of the month age 19/End of the year age 23
Annual Deductible (Individual/Family)	N/A	$250/$650	N/A	N/A	$250/$650	N/A
Annual Out-of-Pocket Maximum (Indiv/Family) (Excl. Deductible)	N/A	$1200/$2400	$1500/$3000	N/A	$1200/$2400	N/A
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Pre-Existing Condition Limitation	N/A	N/A	N/A	N/A	N/A	N/A
Office Visits	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full
Emergency Room (Accident/Illness)	Covered in full	Emergency: Covered in full Non-emergency:80% of R&C after deductible	Covered in full after $35 co-pay (waived if admitted)	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after $50 co-pay (waived if admitted)
Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)	Covered in full Pre-admission certification required or $250 penalty plus 50% reduction in benefits on any days not approved.	Covered in full	Covered in full	Covered in full Pre-admission certification required or $250 penalty plus 50% reduction in benefits on any days not approved.	Covered in full	Covered in full
(Physician/Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	80% of R&C after deductible	Covered in full
Second Surgical Opinion (Office Visit)	Covered in full	100% of R&C	Covered in full after $5 co-pay	Covered in full	100% of R&C	Covered in full
Laboratory/X-Ray	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full	80% of R&C after deductible	Covered in full
Maternity (Initial Visit To Determine Pregnancy)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full
(Subsequent Visits/Delivery)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	80% of R&C after deductible	Covered in full
Prescription Medication (Retail)	$5 generic/$10 brand (up to 30-day supply)	80% of R&C after deductible	$5 generic/$10 brand formulary/ $25 brand non-formulary (up to 30-day supply)	$5 generic/ $10 brand (up to 30-day supply)	80% of R&C after deductible	$5 generic/$10 brand (up to 30-day supply)
(Mail Order)	$10 generic/$20 brand (up to 90-day supply)	Use in-network benefit	$10 generic/$20 brand formulary/$50 brand non-formulary (31 to 90-day supply)	$10 generic/ $20 brand (up to 90-day supply)	In-network only	$7.50 generic/$15 brand (up to 90-day supply)

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	CIGNA OAP (PPO)			Vytra PPO		
	In-Network	**Out-of-Network**	**Aetna (HMO)**	**In–Network**	**Out-of-Network**	**HIP (HMO)**
Preventive Care (Routine Care For Children Including Immunizations)	Covered in full (to age 19)	80% of R&C after deductible (to age 19)	Covered in full (to age 19)	Covered in full (to age 19)	80% of R&C after deductible	Covered in full (to age 19)
(Well Woman Exam)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full
(Mammogram)	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full	80% of R&C after deductible	Covered in full
(Physical Exam)	Covered in full after $10 co-pay	Not covered	Covered in full after $5 co-pay	Covered in full after $10 co-pay	Not covered	Covered in full
(Routine Eye Exam)	Not covered	Not covered	Covered in full after $5 co-pay	Covered in full after $10 co-pay (1 exam/year)	Not covered	Covered in full (for optometrist in discount program)
Mental Health Care (Inpatient)	Same as inpatient hospital	Same as inpatient hospital	Covered in full (Max: 35 days/year)	Same as inpatient hospital	Same as inpatient hospital	Covered in full (Max: 30 days/year)
(Outpatient)	Covered in full after $10 co-pay/ visit	80% of R&C after deductible	$5 co-pay/visit (Max: 20 visits/year for certain conditions)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full (Max: 20 visits/year for certain conditions)
Substance Abuse Treatment (Inpatient Detox)	Same as inpatient hospital	Same as inpatient hospital	Covered in full	Same as inpatient hospital	Same as inpatient hospital	Covered in full (Max: 7 days/year)
(Outpatient Rehab)	Covered in full after $10 co-pay/ visit	80% of R&C after deductible	$5 co-pay/visit (Max: 60 visits/year)	Covered in full after $10 co-pay/ visit	80% of R&C after deductible	Covered in full (Max: 60 visits/year)
Alternate Care (Home Health Care) Non-custodial	Covered in full (Max: 40 visits/year combined in and out of network)	80% of R&C after deductible	$5 co-pay/visit	Covered in full (Max: 40 visits/year combined in/out)	80% of R&C after deductible	Covered in full (Max: 200 visits/year)
(Skilled Nursing Facility) Non-Custodial	Same as inpatient hospital (Max: 60 days/year combined in and out of network)	Same as inpatient hospital	Covered in full	Same as inpatient hospital (Max: 60 days/year combined in/out)	Same as inpatient hospital	Covered in full
(Outpatient Short-Term Rehab: Physical Therapy)	Covered in full after $10 co-pay	80% of R&C after deductible	$5 co-pay (Max: 60 consecutive days/injury/lifetime)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full (Max: 90 visits/year)
Durable Medical Equipment	Covered in full	80% of R&C after deductible	Not covered	Covered in full	80% of R&C after deductible	Covered in full
External Prosthetic Devices	Covered in full	80% of R&C after deductible	Covered in full for initial device only	Covered in full	80%of R&C after deductible	Covered in full
Hearing Aids	Covered in full ------(Max: $2000/1095 days)-----	80% of R&C after deductible	Not covered	Not covered	Not covered	Not covered

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